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Topics in Minority Health

Safety-Belt Use and Motor-Vehicle–Related Injuries — Navajo Nation, 1988–1991

Injuries are the second leading cause of death among American Indians and Alaskan Natives; during 1986–1988, injuries accounted for 22% of all deaths (*1*). The risk for motor-vehicle–related injury deaths is nearly threefold higher among American Indians and Alaskan Natives than among the total U.S. population (age-adjusted death rates: 57.5 per 100,000 versus 19.5 per 100,000) (*1–3*). For residents of many rural, western, Indian reservations, age-adjusted motor-vehicle–related death rates are substantially higher; in particular, the rates for Navajos* are fivefold greater than for the total U.S. population (97.9 per 100,000 versus 19.5 per 100,000) (*1*) and almost three times the rate for all New Mexico residents (35.2 per 100,000) (*4*). To increase safety-belt use by front-seat occupants and thereby reduce motor-vehicle–related injuries, the Navajo Area Indian Health Service (IHS) Office of Environmental Health and Engineering, the Navajo Department of Highway Safety, and the Navajo Nation implemented a primary enforcement† safety-belt use law and educational campaign. This report summarizes results of their effort.

The initial focus of the Navajo safety-belt campaign was to build support among tribal leaders for passage of a safety-belt use law§ for the Navajo Nation. In July 1988, the Navajo Nation enacted a primary enforcement safety-belt use law. The campaign then initiated an intensive public information program about the new law and the benefits of safety-belt use. Enforcement (i.e., issuing citations for nonuse of safety belts), the last major component of the campaign, was initiated by the Navajo Nation

*The Navajo Nation is one of the largest American Indian tribes in the United States (estimated 1990 population: 191,000) and territorially includes parts of Arizona, New Mexico, and Utah, with a land size comparable to the state of West Virginia.

†Primary enforcement of safety-belt use laws permit law enforcement officers to stop drivers for a safety-belt use violation alone, whereas secondary enforcement laws require that a vehicle must first be stopped for some other traffic violation.

§Federally recognized Indian tribes and their reservations are considered sovereign nations, where some state motor-vehicle codes such as mandatory occupant-restraint laws often do not apply.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / Public Health Service

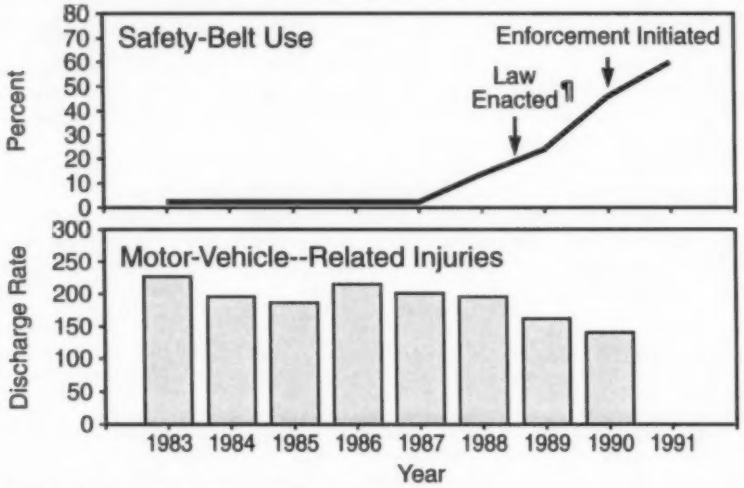
Navajo Nation — Continued

Department of Law Enforcement in January 1990, with rigorous widespread enforcement in place by June 1990.

In June 1988, trained IHS staff conducted baseline observational surveys of safety-belt use by front-seat occupants at sites throughout the Navajo Nation; the surveys continued on a monthly basis by IHS and Navajo Nation Department of Highway Safety staff and are ongoing. Safety-belt use in the Navajo Nation from 1983 through 1987 was estimated from observational surveys conducted by IHS staff in 1985. Information on motor-vehicle–related injuries was obtained from an E-coded (*International Classification of Diseases, Ninth Revision, Clinical Modification,* external cause-of-injury codes) hospital discharge data base maintained by the IHS. All American Indian residents of the Navajo Nation are eligible for medical care from the IHS. Only motor-vehicle–related traffic injuries involving either the driver or an occupant (E810–E819) were selected.

From June 1988 through September 1991, the prevalence of safety-belt use on the Navajo Nation increased from 14% to 60% (Figure 1). In June 1988 before the law was passed, rates of safety-belt use were low for males and females (13.8% and 14.4%, respectively); sex-specific data for subsequent periods were not complete. During the baseline survey, a total of 6109 vehicles were observed; 58% of these were driven by males. Most (56%) vehicles were pickup trucks; 678 persons were observed riding in the back of pickup trucks.

FIGURE 1. Comparison of percentage of safety-belt use* and hospital discharge rate† for motor-vehicle–related injuries — Navajo Nation,§ 1983–1991



*Projected data for 1983–1987 are based on a 1985 survey.
†Per 100,000 Navajo Nation residents served by the Navajo Area Indian Health Service (IHS).
§Includes all Navajo Nation residents of the Navajo reservation using IHS services.
¶The Navajo Nation safety-belt law was passed in July 1988.

Navajo Nation — Continued

From 1988 through 1990, motor-vehicle–related injury hospitalization rates for Navajo Indians decreased 28.5%, from 196.3 per 100,000 to 140.3 per 100,000 (Figure 1). During this period, rates for injury hospitalization decreased more for females than for males (46% versus 14%) (Table 1).

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Editorial Note: Safety-belt use in the United States increased from 11% in 1982 to 59% in 1991, reflecting the passage and enforcement of mandatory safety-belt use legislation (*5*). The National Highway Traffic Safety Administration estimates that among front-seat passenger-vehicle occupants aged >4 years safety-belt use prevented 4800 deaths and 125,000 moderate to critical injuries in 1990 (*6*). The trends in this report suggest efforts to increase safety-belt use in targeted high-risk populations can decrease the risk for motor-vehicle–related injuries.

American Indians and Alaskan Natives are at increased risk for motor-vehicle–related deaths and injuries for at least three reasons. First, because many American Indians and Alaskan Natives live in rural areas, their access to advanced emergency medical care may be limited when a crash occurs, and as a consequence, treatment for injuries may be delayed. Second, American Indians and Alaskan Natives may travel more on isolated two-lane highways and ride unprotected (e.g., unrestrained) in the back of open pickup trucks (*3*), placing them at higher risk for injury if a crash occurs. Third, this population is younger than the total U.S. population (median age: 23 years versus 30 years); young persons are at higher risk for injury because of risk-taking behaviors, such as drinking and driving and not wearing safety belts. Such risk factors also contributed to high death rates among Navajo residents: from 1986 to 1988, the Navajo Nation had the second highest motor-vehicle–related death rate of all 12 IHS geographic areas (*1*). In addition, because alcohol is not legally available in the Navajo Nation, those residents who drink may drive long distances while impaired.

The findings in this report indicated that the decline in motor-vehicle–related injury rates was greater for Navajo females than males. Potential explanations for this difference are that 1) more Navajo women than men may have begun wearing safety belts after the law was passed; 2) males may spend more time as motor-vehicle occupants

TABLE 1. Motor-vehicle–related driver and occupant injuries* among Navajo Indians, by sex — Navajo Nation,† 1985–1990

Year	Males		Females	
	No. injured	Injury rate§	No. injured	Injury rate§
1985	192	237.6	120	139.9
1986	224	269.7	145	164.4
1987	210	246.0	145	160.0
1988	193	219.9	162	173.9
1989	172	190.7	131	136.8
1990	175	188.9	93	94.5

* *International Classification of Diseases, Ninth Revision, Clinical Modification*, codes E810–E819.
† Includes all Navajo tribal members living on the Navajo reservation and using Indian Health Service (IHS) services.
§ Hospital discharges per 100,000 Navajo Nation residents served by the Navajo Area IHS.

Navajo Nation — Continued

than females; and 3) males who do not use safety-belts engage in risky driving behavior more often than males who do use safety belts (*7*). Special efforts may be needed to target high-risk behavior, such as impaired driving and riding unprotected in the back of pickup trucks.

Although the decline in motor-vehicle–related injuries coincided temporally with increased safety-belt use in the Navajo Nation, a clear causal relation could not be established. Other factors that may have contributed include fewer persons driving while under the influence of alcohol, use of safer motor vehicles, corrections of roadway hazards, and occurrence of fewer crashes.

The Navajo Nation safety-belt use law and campaign is an example of a successful comprehensive program to increase safety-belt use and reduce motor-vehicle–related injury. The strategy used by the Navajo Nation—integrating public education and strict enforcement of a safety-belt law—has been implemented with success elsewhere to increase safety-belt use (*5*). As of August 1992, 41 states have passed mandatory safety-belt use laws; only 13 of 510 American Indian tribes have implemented safety-belt use laws on federal reservations. The enactment and enforcement of a primary enforcement safety-belt use law for the Navajo Nation is assisting in reducing the disproportionate impact of motor-vehicle–related injury and death among the Navajo population.

References

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Current Trends

Increased HIV/AIDS Mortality Among Residents Aged 25–44 Years — Baltimore, Maryland, 1987–1989

From 1987 through 1989, overall mortality among Baltimore residents aged 25–44 years increased from 380.7 deaths per 100,000 residents to 452.6 deaths per 100,000, reflecting the substantial impact of human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS). To better characterize this increase in mortality, the Baltimore City Health Department analyzed information on death certificates from the Baltimore City Bureau of Vital Statistics for persons aged

HIV/AIDS Mortality — Continued

25–44 years for 1987–1989. This report summarizes the analysis and characterizes HIV-infection/AIDS-related deaths among residents of Baltimore in this age group.

Of the five leading causes of death in Baltimore, the increase was greatest for HIV infection/AIDS (*International Classification of Diseases, Ninth Revision* [ICD-9], codes 042–044); the rate for persons aged 25–44 years more than doubled (Table 1). In 1989, mortality attributable to HIV infection/AIDS was more than three times the national rate; the impact was greatest among black* men, accounting for 15.5% of all deaths in this group.

From 1987 through 1989, HIV-infection/AIDS-related deaths among black men more than doubled (Table 1). In 1987, HIV infection/AIDS was the third leading cause of death for this group (64.6 deaths per 100,000; n=40) but by 1988, had become the leading cause of death (114.9; n=73). In 1989, the death rate for this group increased to 137.1 (n=90). HIV-infection/AIDS-related mortality among white men also increased: among this group, HIV-infection/AIDS-related mortality was the sixth leading cause of death in 1987 (19.9; n=9), but had become the leading cause of death in 1989 (65.3; n=29).

In 1988, HIV infection/AIDS was the third leading cause of death (22.6 deaths per 100,000; n=17) for black women (Table 1); by 1989, HIV infection/AIDS had become the second leading cause of death (34.9; n=27), surpassed only by heart disease.

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Editorial Note: The high HIV-infection/AIDS-related death rate for persons aged 25–44 years in Baltimore reflects the increasing burden of disease associated with HIV infection/AIDS in certain U.S. metropolitan areas. In San Francisco, Los Angeles, New York City, and Baltimore, HIV infection/AIDS has become the leading cause of death among young adult men, surpassing heart disease, cancer, and homicide (*1*).

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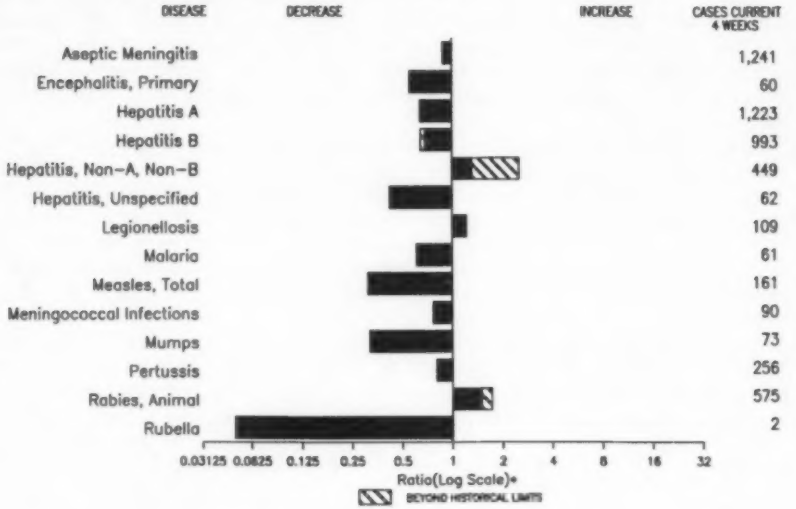
*Numbers for racial/ethnic groups other than white and black were too small (less than 2% of the population) for use in this analysis.

TABLE 1. Deaths and death rate* attributable to HIV infection/AIDS among persons aged 25–44 years, by year, sex, and race† — Baltimore, Maryland, 1987–1989

	1987		1988		1989	
Sex/Race	No.	Rate	No.	Rate	No.	Rate
Men						
Black	40	64.6	73	114.9	90	137.1
White	9	19.9	16	35.6	29	65.3
Women						
Black	4	5.4	17	22.6	27	34.9
White	0	—	0	—	1	2.3
Total	53	23.6	106	46.7	147	63.8

* Per 100,000 population.
† Numbers for racial/ethnic groups other than white and black were too small (represent less than 2% of the population) for use in this analysis.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending September 19, 1992, with historical data — United States



*Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending September 19, 1992 (38th Week)

	Cum. 1992		Cum. 1992
AIDS*	31,455	Measles: imported	114
Anthrax	1	indigenous	1,882
Botulism: Foodborne	13	Plague	7
Infant	40	Poliomyelitis, Paralytic†	-
Other	1	Psittacosis	60
Brucellosis	56	Rabies, human	-
Cholera	96	Syphilis, primary & secondary	24,807
Congenital rubella syndrome	8	Syphilis, congenital, age < 1 year§	897
Diphtheria	4	Tetanus	18
Encephalitis, post-infectious	93	Toxic shock syndrome	180
Gonorrhea	352,015	Trichinosis	22
Haemophilus influenzae (invasive disease)	1,000	Tuberculosis	16,084
Hansen Disease	111	Tularemia	121
Leptospirosis	21	Typhoid fever	271
Lyme Disease	5,320	Typhus fever, tickborne (RMSF)	357

*Updated monthly; last update September 8, 1992.
†Two cases of suspected poliomyelitis have been reported in 1992; 6 of the 9 suspected cases with onset in 1991 were confirmed and 5 of the 8 suspected cases with onset in 1990 were confirmed; all were vaccine associated.
§Reports through first quarter 1992.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending September 19, 1992, and September 21, 1991 (38th Week)

Reporting Area	AIDS*	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	31,455	6,558	456	93	352,015	434,118	14,575	11,369	5,235	516	947	5,320
NEW ENGLAND	1,017	247	20	-	7,536	10,465	427	425	78	17	47	1,250
Maine	35	26	2	-	60	123	28	19	6	-	2	4
N.H.	32	11	2	-	92	154	29	30	20	1	5	32
Vt.	21	12	3	-	19	41	8	11	11	-	2	5
Mass.	550	112	10	-	2,723	4,582	212	334	35	16	28	160
R.I.	67	86	3	-	512	877	106	18	6	-	10	206
Conn.	312	-	-	-	4,130	4,688	44	13	-	-	-	843
MID. ATLANTIC	8,345	567	19	8	38,487	51,772	1,103	1,439	255	16	256	2,976
Upstate N.Y.	1,060	278	-	-	7,107	9,145	248	358	158	8	98	1,838
N.Y. City	4,884	104	4	1	13,571	20,305	475	282	4	-	5	11
N.J.	1,543	-	-	-	5,494	8,303	172	356	67	-	27	439
Pa.	858	185	15	7	12,315	14,019	208	443	26	10	126	688
E.N. CENTRAL	2,775	960	114	27	66,810	80,266	2,047	1,726	1,003	29	244	98
Ohio	518	281	34	2	20,290	24,224	315	174	68	4	111	42
Ind.	267	132	10	11	6,403	8,111	615	584	484	10	27	28
Ill.	1,301	208	46	6	22,063	24,513	409	204	62	5	23	6
Mich.	540	322	22	8	15,232	17,652	107	441	330	10	55	22
Wis.	149	17	2	-	2,822	5,766	601	323	59	-	28	-
W.N. CENTRAL	880	347	27	6	16,217	21,230	1,817	481	195	27	57	226
Minn.	161	37	7	-	2,109	2,159	506	52	14	2	5	92
Iowa	66	47	-	3	1,123	1,459	34	27	5	3	14	15
Mo.	446	161	6	-	9,237	12,938	675	320	146	20	21	95
N. Dak.	8	1	3	-	46	57	81	1	3	1	2	1
S. Dak.	7	8	-	1	129	259	192	4	-	-	-	1
Nebr.	40	20	4	2	8	1,364	221	29	15	1	13	9
Kans.	152	73	5	-	3,565	2,994	108	48	12	-	2	13
S. ATLANTIC	7,268	1,108	112	39	106,813	129,122	933	1,890	727	87	137	436
Del.	95	41	6	-	1,293	2,065	37	165	154	1	22	164
Md.	824	138	12	-	11,344	13,673	167	302	29	6	25	104
D.C.	486	21	1	-	4,383	6,750	13	58	258	-	7	2
Va.	433	183	30	11	11,669	13,113	85	143	28	30	13	92
W. Va.	42	22	38	-	652	908	7	42	2	22	-	7
N.C.	482	132	21	-	17,606	25,802	78	317	65	-	27	42
S.C.	257	18	-	-	8,284	10,588	21	42	1	1	16	1
Ga.	928	140	2	-	31,730	30,045	134	221	86	-	7	3
Fla.	3,721	413	2	28	19,852	26,178	391	600	104	27	20	21
E.S. CENTRAL	1,007	340	19	-	35,139	43,641	215	947	1,511	2	49	52
Ky.	152	122	11	-	3,506	4,380	65	66	3	-	21	18
Tenn.	321	68	4	-	10,556	15,099	91	780	1,496	-	22	26
Ala.	357	97	3	-	12,601	13,586	35	97	11	1	6	8
Miss.	177	53	1	-	8,476	10,576	24	4	1	1	-	-
W.S. CENTRAL	2,897	869	42	5	39,619	49,078	1,404	1,367	107	114	19	93
Ark.	151	10	7	-	5,286	5,791	82	59	7	4	-	11
La.	541	47	5	1	10,975	11,069	166	142	51	2	3	5
Okla.	189	-	3	2	3,988	5,085	147	154	30	3	9	23
Tex.	2,016	812	27	2	19,370	27,133	1,009	1,012	19	105	7	54
MOUNTAIN	880	228	22	4	8,794	9,025	2,140	537	210	46	73	15
Mont.	14	5	1	1	84	73	74	27	27	-	9	-
Idaho	22	23	-	-	80	113	62	64	-	1	4	2
Wyo.	2	3	2	-	42	73	9	8	38	-	1	5
Colo.	293	75	7	1	3,092	2,603	603	83	70	20	14	-
N. Mex.	68	19	3	1	685	740	217	153	18	8	2	2
Ariz.	284	61	6	-	3,087	3,326	826	118	22	11	25	-
Utah	54	10	3	1	238	223	279	12	22	6	1	6
Nev.	143	32	-	-	1,486	1,874	68	72	13	-	17	-
PACIFIC	6,386	1,892	81	4	32,600	39,519	4,489	2,557	1,149	176	65	174
Wash.	390	-	1	-	2,658	3,356	549	258	112	7	10	10
Oreg.	166	-	-	-	1,216	1,511	293	198	54	9	-	-
Calif.	5,725	1,817	73	3	27,834	33,446	3,462	2,075	810	152	54	163
Alaska	11	12	7	-	502	640	43	12	2	1	-	-
Hawaii	94	63	-	1	390	566	142	14	171	7	1	1
Guam	-	2	-	-	48	12	5	1	-	6	-	1
P.R.	878	136	1	-	169	423	37	322	151	17	1	-
V.I.	2	-	-	-	73	293	3	6	-	-	-	-
Amer. Samoa	-	-	-	-	31	38	1	1	-	-	-	-
C.N.M.I.	-	-	-	-	61	60	1	-	-	-	-	-

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly; last update September 8, 1992.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending September 19, 1992, and September 21, 1991 (38th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	1992	Cum. 1992	Cum. 1991
UNITED STATES	669	44	1,882	5	114	8,764	1,843	16	1,955	57	1,605	1,919	-	138	1,275
NEW ENGLAND	39	5	54	3	13	74	99	1	15	7	161	238	-	6	4
Maine	1	-	-	1[†]	4	2	8	-	-	3	11	49	-	1	-
N.H.	3	-	15	-	-	-	5	-	3	-	29	17	-	-	1
Vt.	-	-	-	-	-	5	4	-	1	-	6	4	-	-	-
Mass.	21	5	16	2[†]	5	35	41	1	3	4	80	142	-	-	2
R.I.	5	U	23	U	-	2	3	U	-	U	1	-	U	4	-
Conn.	9	-	-	-	4	30	38	-	8	-	34	26	-	1	1
MID. ATLANTIC	172	-	173	-	13	4,595	183	1	117	2	125	182	-	18	565
Upstate N.Y.	27	-	81	-	4	400	87	-	54	1	39	100	-	11	539
N.Y. City	95	-	42	-	8	1,710	16	-	12	-	9	20	-	-	2
N.J.	25	-	45	-	1	1,026	25	-	9	-	16	14	-	2	2
Pa.	25	-	5	-	-	1,459	55	1	42	1	61	48	-	3	22
E.N. CENTRAL	45	-	28	-	14	82	243	1	250	4	167	358	-	8	319
Ohio	8	-	-	-	6	3	61	-	90	-	50	80	-	-	283
Ind.	11	-	20	-	-	3	38	-	8	1	23	65	-	-	3
Ill.	12	-	6	-	4	26	64	-	80	-	22	67	-	8	7
Mich.	11	-	2	-	2	41	60	1	62	1	9	33	-	-	25
Wis.	3	-	-	-	2	9	20	-	10	2	63	113	-	-	1
W.N. CENTRAL	34	-	6	-	8	52	74	1	63	-	155	146	-	7	17
Minn.	15	-	5	-	5	20	11	-	19	-	32	51	-	-	6
Iowa	2	-	-	-	3	17	8	-	10	-	5	16	-	3	6
Mo.	10	-	-	-	-	1	23	1	26	-	88	58	-	-	5
N. Dak.	1	-	-	-	-	-	1	-	2	-	13	3	-	-	-
S. Dak.	1	-	-	-	-	-	1	-	-	-	11	4	-	-	-
Nebr.	1	-	-	-	-	1	14	-	4	-	10	8	-	-	-
Kans.	4	-	1	-	-	13	16	-	2	-	18	6	-	4	-
S. ATLANTIC	134	-	122	-	12	481	342	3	715	2	121	197	-	15	8
Del.	5	-	3	-	-	21	2	2	8	1	7	-	-	-	-
Md.	36	-	9	-	7	176	28	1	63	-	20	47	-	6	1
D.C.	9	-	-	-	-	-	3	-	5	-	1	1	-	1	1
Va.	30	-	11	-	4	30	49	-	49	-	10	18	-	-	-
W. Va.	2	-	-	-	-	-	16	-	22	-	7	9	-	1	-
N.C.	8	-	25	-	-	44	103	-	180	-	22	32	-	-	2
S.C.	-	-	29	-	-	13	21	-	49	1	12	11	-	2	-
Ga.	5	-	2	-	1	15	45	-	70	-	14	38	-	-	-
Fla.	39	-	43	-	-	182	75	-	269	-	28	41	-	5	4
E.S. CENTRAL	16	-	445	-	18	5	108	1	47	-	24	73	-	1	100
Ky.	1	-	444	-	2	1	31	-	-	-	1	-	-	-	-
Tenn.	11	-	-	-	-	3	34	-	14	-	6	29	-	1	100
Ala.	4	-	-	-	-	1	32	1	12	-	14	40	-	-	-
Miss.	-	-	1	-	16	-	11	-	21	-	3	4	-	-	-
W.S. CENTRAL	22	39	938	2	3	195	119	6	295	1	50	71	-	-	7
Ark.	1	-	-	-	-	5	10	-	6	-	15	8	-	-	1
La.	1	-	-	-	-	-	26	-	20	-	7	13	-	-	-
Okla.	5	-	11	-	-	-	13	-	17	1	28	27	-	-	-
Tex.	15	39	925	2[§]	3	190	70	6	252	-	-	23	-	-	6
MOUNTAIN	23	-	17	-	8	1,176	79	1	113	6	277	247	-	8	21
Mont.	-	-	-	-	-	-	14	-	2	-	4	3	-	-	-
Idaho	1	-	-	-	-	433	8	-	3	-	37	23	-	1	-
Wyo.	-	-	1	-	-	3	2	-	-	-	-	3	-	-	-
Colo.	5	-	13	-	7	6	14	-	17	-	26	106	-	1	2
N. Mex.	4	-	1	-	1	98	8	N	N	4	70	29	-	-	1
Ariz.	8	-	2	-	-	393	19	1	64	2	110	57	-	2	2
Utah	4	-	-	-	-	224	4	-	19	-	28	24	-	2	11
Nev.	1	-	-	-	-	19	10	-	8	-	2	2	-	2	5
PACIFIC	184	-	101	-	25	2,104	396	1	240	35	525	407	-	75	234
Wash.	13	-	-	-	10	61	64	-	9	8	163	103	-	6	8
Oreg.	11	-	3	-	1	80	55	N	N	1	31	58	-	3	3
Calif.	152	-	56	-	3	1,932	263	1	211	25	307	192	-	44	213
Alaska	1	-	8	-	1	5	8	-	1	-	7	12	-	-	1
Hawaii	7	-	34	-	10	26	6	-	19	1	17	42	-	22	9
Guam	2	U	10	U	-	-	-	U	10	U	-	-	U	1	-
P.R.	-	-	339	-	-	94	3	-	1	-	11	47	-	-	1
V.I.	-	-	-	-	-	2	-	-	18	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	24	-	-	-	-	6	-	-	-	-
C.N.M.I.	-	U	1	U	1	-	-	U	-	U	1	-	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.
N: Not notifiable U: Unavailable [†] International [§] Out-of-state

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending September 19, 1992, and September 21, 1991 (38th Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic-Shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	24,607	30,642	180	18,084	18,339	121	271	357	5,932
NEW ENGLAND	489	761	11	345	473	1	24	7	597
Maine	2	1	1	19	30	-	-	-	-
N.H.	38	12	6	14	5	-	1	-	6
Vt.	1	1	-	6	6	-	-	-	21
Mass.	243	358	3	171	234	1	15	3	11
R.I.	24	42	1	34	75	-	-	2	-
Conn.	181	347	-	101	123	-	8	2	559
MID. ATLANTIC	3,593	5,275	22	3,737	3,773	-	69	29	1,837
Upstate N.Y.	235	487	8	265	345	-	8	13	1,032
N.Y. City	1,943	2,641	-	2,320	2,284	-	28	4	10
N.J.	442	918	-	682	625	-	21	4	550
Pa.	973	1,229	14	470	519	-	12	8	245
E.N. CENTRAL	3,640	3,674	45	1,595	1,632	1	35	25	120
Ohio	570	487	14	239	249	-	6	13	12
Ind.	221	137	10	126	159	-	1	6	17
Ill.	1,655	1,729	5	796	860	1	23	2	23
Mich.	699	891	16	372	292	-	3	1	14
Wis.	495	430	-	60	72	-	2	3	54
W.N. CENTRAL	947	577	31	375	377	53	5	24	887
Minn.	62	51	6	101	69	-	2	-	143
Iowa	34	55	5	32	52	-	1	1	143
Mo.	731	387	7	168	166	38	1	18	19
N. Dak.	1	1	2	2	6	-	-	-	127
S. Dak.	-	1	-	19	27	11	-	1	102
Nebr.	1	12	4	16	15	2	1	-	12
Kans.	118	70	7	37	42	2	-	4	341
S. ATLANTIC	6,697	9,019	22	3,011	3,074	5	22	102	1,310
Del.	156	121	3	39	22	-	-	10	155
Md.	484	726	2	251	266	1	5	14	397
D.C.	298	554	-	84	132	-	1	1	14
Va.	493	693	3	260	255	2	2	17	245
W. Va.	15	21	1	73	51	-	1	5	32
N.C.	1,749	1,425	3	385	416	1	-	39	28
S.C.	927	1,126	1	307	316	-	1	6	130
Ga.	1,348	2,253	5	624	613	1	-	7	268
Fla.	1,227	2,100	4	988	1,003	-	12	3	41
E.S. CENTRAL	3,079	3,401	3	1,033	1,092	5	3	67	147
Ky.	115	71	-	284	259	1	-	6	55
Tenn.	809	1,109	3	284	322	4	-	58	29
Ala.	1,095	1,299	-	296	292	-	-	3	62
Miss.	1,060	922	-	169	219	-	3	-	1
W.S. CENTRAL	4,599	5,419	2	1,857	1,987	29	10	89	586
Ark.	600	478	-	151	166	19	-	13	32
La.	1,850	1,867	-	139	165	-	1	-	7
Okla.	257	141	1	114	124	10	-	75	269
Tex.	1,892	2,933	1	1,453	1,512	-	9	1	258
MOUNTAIN	257	425	16	412	446	22	3	9	139
Mont.	7	6	1	-	6	12	-	3	18
Idaho	1	4	1	18	5	-	1	1	1
Wyo.	3	8	-	-	3	1	-	3	23
Colo.	35	65	6	30	46	4	2	-	18
N. Mex.	29	24	2	60	59	4	-	1	7
Ariz.	134	265	2	197	234	-	-	-	56
Utah	7	6	4	58	40	-	-	1	5
Nev.	41	47	-	49	53	1	-	-	11
PACIFIC	1,306	2,091	28	3,719	3,505	5	100	5	329
Wash.	65	136	-	220	212	2	7	-	-
Oreg.	31	56	1	93	84	-	-	2	2
Calif.	1,197	1,891	27	3,185	3,009	1	88	3	314
Alaska	5	4	-	40	54	2	-	-	13
Hawaii	8	4	-	181	146	-	5	-	-
Guam	3	1	-	42	6	-	3	-	-
P.R.	250	315	-	174	167	-	1	-	31
V.I.	52	84	-	3	2	-	-	-	-
Amer. Samoa	-	-	-	-	2	-	1	-	-
C.N.M.I.	5	3	-	44	10	-	1	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending September 19, 1992 (38th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	623	411	109	77	10	15	48
Boston, Mass.	182	91	43	35	6	7	14
Bridgeport, Conn.	41	33	3	5	-	-	7
Cambridge, Mass.	23	20	2	-	-	-	1
Fall River, Mass.	22	17	4	1	-	-	-
Hartford, Conn.	51	27	13	9	1	1	-
Lowell, Mass.	38	29	7	2	-	-	2
Lynn, Mass.	11	11	-	-	-	-	2
New Bedford, Mass.	23	15	4	4	-	-	-
New Haven, Conn.	44	27	11	6	-	-	3
Providence, R.I.	36	27	5	4	-	-	-
Somerville, Mass.	7	5	2	-	-	-	1
Springfield, Mass.	54	39	3	6	3	3	8
Waterbury, Conn.	31	26	2	3	-	-	2
Worcester, Mass.	60	44	10	2	-	4	8
MID. ATLANTIC	2,635	1,698	495	314	78	51	104
Albany, N.Y.	45	32	6	4	1	2	1
Allentown, Pa.	25	20	4	-	1	-	-
Buffalo, N.Y.	100	73	18	5	-	4	3
Camden, N.J.	30	14	8	3	4	1	-
Elizabeth, N.J.	16	12	3	1	-	-	2
Erie, Pa.§	44	29	12	2	-	1	2
Jersey City, N.J.	61	37	10	11	1	2	4
New York City, N.Y.	1,454	881	286	219	43	25	54
Newark, N.J.	11	4	2	5	-	-	1
Paterson, N.J.	18	11	4	2	-	1	1
Philadelphia, Pa.	400	267	73	35	18	7	19
Pittsburgh, Pa.§	56	37	10	6	3	-	1
Reading, Pa.	23	17	4	2	-	-	1
Rochester, N.Y.	132	100	21	5	2	4	4
Schenectady, N.Y.	20	16	4	-	-	-	-
Scranton, Pa.§	39	28	7	3	-	1	4
Syracuse, N.Y.	85	63	11	4	4	3	3
Trenton, N.J.	24	18	3	3	-	-	1
Utica, N.Y.	25	20	2	2	1	-	1
Yonkers, N.Y.	28	19	7	2	-	-	3
E.N. CENTRAL	2,327	1,350	491	261	156	69	104
Akron, Ohio	44	28	12	3	1	-	-
Canton, Ohio	43	34	3	3	2	1	3
Chicago, Ill.	594	202	132	128	103	29	15
Cincinnati, Ohio	103	73	25	3	2	-	4
Cleveland, Ohio	152	71	48	17	6	10	3
Columbus, Ohio	174	111	39	17	4	3	4
Dayton, Ohio	109	79	24	4	2	-	6
Detroit, Mich.	208	115	47	26	10	10	3
Evansville, Ind.	32	20	9	3	-	-	1
Fort Wayne, Ind.	56	38	8	6	2	2	3
Gary, Ind.	19	10	4	3	2	-	1
Grand Rapids, Mich.	73	56	9	8	-	-	6
Indianapolis, Ind.	232	150	47	19	11	5	13
Madison, Wis.	36	28	4	1	2	1	-
Milwaukee, Wis.	120	87	28	3	2	-	11
Peoria, Ill.	57	36	13	3	1	4	6
Rockford, Ill.	42	30	8	2	1	1	5
South Bend, Ind.	53	43	6	3	1	-	5
Toledo, Ohio	115	88	17	5	3	2	8
Youngstown, Ohio	65	51	8	4	1	1	5
W.N. CENTRAL	803	592	116	58	20	16	40
Des Moines, Iowa	70	56	7	4	2	1	4
Duluth, Minn.	28	22	4	1	-	1	1
Kansas City, Kans.	25	13	9	1	1	-	-
Kansas City, Mo.	85	68	7	7	2	1	3
Lincoln, Nebr.	29	21	6	1	-	1	1
Minneapolis, Minn.	221	162	38	12	5	4	16
Omaha, Nebr.	114	83	17	10	2	2	7
St. Louis, Mo.	127	89	15	14	4	5	6
St. Paul, Minn.	51	38	5	4	3	1	2
Wichita, Kans.	53	40	8	4	1	-	-
S. ATLANTIC	1,026	607	241	122	26	30	47
Atlanta, Ga.	185	91	51	31	7	5	4
Baltimore, Md.	116	69	34	20	1	2	8
Charlotte, N.C.	98	58	20	12	4	4	5
Jacksonville, Fla.	103	62	27	11	-	3	4
Miami, Fla.	79	32	27	16	1	3	-
Norfolk, Va.	71	43	15	4	6	3	5
Richmond, Va.	83	51	21	9	-	2	5
Savannah, Ga.	43	33	6	-	2	2	3
St. Petersburg, Fla.	53	36	6	6	-	3	1
Tampa, Fla.	184	124	39	13	5	3	12
Washington, D.C.	U	U	U	U	U	U	U
Wilmington, Del.	11	8	3	-	-	-	-
E.S. CENTRAL	664	425	144	60	24	11	42
Birmingham, Ala.	93	63	16	7	4	3	3
Chattanooga, Tenn.	60	40	12	6	2	-	3
Knoxville, Tenn.	51	37	9	4	1	-	5
Lexington, Ky.	58	33	19	2	2	2	7
Memphis, Tenn.	201	124	44	20	8	5	12
Mobile, Ala.	48	28	12	7	1	-	4
Montgomery, Ala.	43	23	12	4	4	-	-
Nashville, Tenn.	110	77	20	10	2	1	8
W.S. CENTRAL	1,439	858	296	175	66	44	69
Austin, Tex.	81	53	15	8	5	-	4
Baton Rouge, La.	62	39	16	4	1	2	1
Corpus Christi, Tex.	54	39	7	4	2	2	5
Dallas, Tex.	217	121	46	27	15	8	4
El Paso, Tex.	92	49	24	8	6	5	1
Ft. Worth, Tex.	93	67	19	5	2	-	5
Houston, Tex.	347	177	74	66	21	9	33
Little Rock, Ark.	86	55	14	6	5	6	5
New Orleans, La.	84	45	15	16	4	4	-
San Antonio, Tex.	178	114	35	20	5	4	4
Shreveport, La.	51	33	11	5	-	2	4
Tulsa, Okla.	94	66	20	6	-	2	3
MOUNTAIN	767	513	155	63	16	20	63
Albuquerque, N.M.	52	40	9	2	1	-	2
Colo. Springs, Colo.	49	37	7	3	1	1	8
Denver, Colo.	119	83	19	10	-	7	8
Las Vegas, Nev.	135	81	42	11	1	-	9
Ogden, Utah	20	17	1	2	-	-	-
Phoenix, Ariz.	187	115	42	18	5	7	25
Pueblo, Colo.	17	13	3	1	-	-	1
Salt Lake City, Utah	87	48	20	12	6	1	8
Tucson, Ariz.	101	79	12	4	2	4	4
PACIFIC	1,880	1,215	330	219	85	46	117
Berkeley, Calif.	18	16	-	-	1	1	3
Fresno, Calif.	74	49	12	7	1	5	9
Glendale, Calif.	29	22	6	1	-	-	1
Honolulu, Hawaii	90	66	15	6	2	1	12
Long Beach, Calif.	81	59	11	5	3	3	16
Los Angeles, Calif.	489	273	93	81	33	6	15
Pasadena, Calif.	29	18	7	3	-	1	1
Portland, Oreg.	135	87	28	13	5	1	8
Sacramento, Calif.	128	89	19	12	4	4	7
San Diego, Calif.	153	100	24	16	6	6	16
San Francisco, Calif.	157	88	30	33	2	4	-
San Jose, Calif.	176	128	25	15	1	7	9
Santa Cruz, Calif.	32	25	5	2	-	-	7
Seattle, Wash.	150	91	34	18	5	2	2
Spokane, Wash.	44	33	7	3	1	-	4
Tacoma, Wash.	95	71	14	4	1	5	7
TOTAL	12,165¶	7,669	2,377	1,349	481	302	834

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.
†Pneumonia and influenza.
§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.
¶Total includes unknown ages.
U: Unavailable.

HIV/AIDS Mortality — Continued

In 1989, HIV infection/AIDS was the second leading cause of death for men and the sixth leading cause of death for women aged 25–44 years in the United States (*2*). In comparison, in 1989 in Baltimore, HIV-infection/AIDS-related mortality among persons aged 25–44 years was more than twice the national average for white men and three times the national average for black men. The increase of HIV-infection/AIDS-related mortality among blacks reflects the disproportionate representation of minorities in urban communities with a high incidence of HIV infection. The findings in this report also are consistent with national trends that indicate HIV infection/AIDS is becoming a leading cause of death among young women. For example, in New York City, HIV infection/AIDS is now the leading cause of death among women aged 25–44 years (*3*).

In Baltimore and other metropolitan areas, the reduction of new HIV infections will require the cooperative efforts of public and private organizations in providing 1) public information about HIV infection/AIDS; 2) HIV health education and risk-reduction initiatives; 3) HIV counseling, testing, referral, and partner-notification services; and 4) HIV early intervention services. For example, the Baltimore community used the HIV-infection/AIDS-related mortality data at city health conferences and seminars to train health professionals to work with subpopulations within the metropolitan area through the development of 1) a "grass roots" HIV-infection prevention campaign for persons with high-risk behaviors and 2) a needle clean-up program within neighborhoods with high levels of HIV infection.

References

1. CDC. Mortality attributable to HIV infection/AIDS—United States, 1981–1990. MMWR 1991;40:41–4.
2. NCHS. Advance report of final mortality statistics, 1989. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1992. (Monthly vital statistics report; vol 40, no. 8, suppl 2).
3. New York City Department of Health. AIDS surveillance update. New York: New York City Department of Health, 1991.

Elevated Blood Lead Levels in Adults — United States, Second Quarter, 1992

In the United States, more than 95% of elevated blood lead levels (BLLs) in adults result from workplace exposure (*1*). Beginning with this issue of *MMWR*, CDC's National Institute for Occupational Safety and Health (NIOSH) will report on a quarterly basis summary results of state-based surveillance programs for elevated BLLs (≥25 µg/dL) among adults (Table 1). In addition to the 18 states with blood lead surveillance programs previously reported (*2*), three other states maintain such activities, including Arizona (physician reporting of BLLs ≥25 µg/dL, all ages), Florida (laboratory reporting of BLLs ≥10 µg/dL, all ages), and Nebraska (laboratory reporting of BLLs ≥10 µg/dL, all ages).

Of the 21 states, 12 currently maintain the data-entry and analytic capability necessary to provide quarterly reports. In 1992, NIOSH will assist the other states in standardizing reporting fields and in providing for timely analysis of their data.

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Blood Lead Levels — Continued

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TABLE 1. Reports of elevated blood lead levels (BLLs) in adults — 12 states,* second quarter, 1992

Reported BLL (μg/dL)	Second quarter, 1992	Cumulative, 1992	Cumulative, 1991†
25–39	2861	6336	—
40–49	632	1536	—
50–59	159	380	—
≥60	105	191	—
Total	**3757**	**8443**	**9994**

* Alabama, California, Connecticut, Illinois, Iowa, Maryland, Massachusetts, New Jersey, New York, Oregon, Texas, and Wisconsin.
† Data stratified by BLL not available for 1991. Cumulative through second quarter 1991.

References

1. Rabin R, Davis L, Brooks D. Lead at work: elevated blood lead levels in Massachusetts, April–October 1991. Boston: Occupational Lead Registry, Division of Occupational Hygiene, Massachusetts Department of Labor and Industries, and Occupational Health Surveillance Program, Bureau of Statistics, Research and Evaluation, Massachusetts Department of Public Health, 1992.
2. CDC. Surveillance of elevated blood lead levels among adults—United States, 1992. MMWR 1992;41:285–8.

Notices to Readers

Announcement of Meeting on Tuberculosis Prevention in Health-Care Facilities

CDC will sponsor a meeting, "Issues in Preventing Tuberculosis Transmission in Health-Care Facilities," October 22–23, 1992, in Atlanta. The goal of the meeting is to review and assess the need to revise CDC guidelines for reducing the risk for tuberculosis (TB) transmission in health-care settings (*1*).

The meeting will bring together experts in TB prevention and control, nosocomial infection prevention, biosafety, and occupational safety and health, as well as representatives of labor, medical, hospital, and administration organizations. Topics will include patient management; TB isolation precautions; engineering controls, such as ventilation and ultraviolet irradiation; health-care worker TB screening; and personal respiratory protection, including discussion of recent recommendations by CDC's National Institute for Occupational Safety and Health (*2*).

Notices to Readers — Continued

There is no registration fee. Additional information and a preliminary agenda are available from CDC's Division of Tuberculosis Elimination, National Center for Prevention Services, 1600 Clifton Road, NE, Mailstop E-10, Atlanta, GA 30333; telephone (404) 639-2501; fax (404) 639-1450.

References

1. CDC. Guidelines for preventing the transmission of tuberculosis in health-care settings, with special focus on HIV-related issues. MMWR 1990;39(no. RR-17).
2. NIOSH. NIOSH recommended guidelines for personal respiratory protection of workers in health-care facilities potentially exposed to tuberculosis. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, September 14, 1992.

International Course in Surveillance and Applied Epidemiology for HIV Infection and AIDS

CDC, the Emory University School of Public Health, the Fogarty International Center of the National Institutes of Health, the Global Program on AIDS of the World Health Organization, the Pan American Health Organization, and the U.S. Agency for International Development will cosponsor the third International Course in Surveillance and Applied Epidemiology for HIV and AIDS September 13–October 1, 1993, at CDC. The course is designed for public health officials from developing countries who are responsible for monitoring HIV infection and AIDS in their countries. Participants will learn basic skills in surveillance, epidemiology, and the development of prevention strategies for HIV infection and AIDS.

The course will be conducted in English. There is a tuition fee. The deadline for application is December 30, 1992. Additional information is available from PACE Enterprises, Inc., Attention: Yvonne Chrimes, 17 Executive Park Drive, Suite 200, Atlanta, GA 30329; telephone (404) 633-8610; fax (404) 633-8745; or Telex 54957 CDCATL (Attention: NCID, DHA, E-50).

Quarterly Table Reporting Alcohol Involvement in Fatal Motor-Vehicle Crashes

The following table reports alcohol involvement in fatal motor-vehicle crashes in the United States for July–September 1991. This table, published quarterly in *MMWR*, focuses attention on the impact of alcohol use on highway safety.

A fatal crash is considered alcohol-related by the National Highway Traffic Safety Administration (NHTSA) if either a driver or nonoccupant (e.g., pedestrian) had a blood alcohol concentration (BAC) of ≥0.01 g/dL in a police-reported traffic crash. Those with a BAC ≥0.10 g/dL (the legal level of intoxication in most states) are considered intoxicated. Because BAC levels are not available for all persons in fatal crashes, NHTSA estimates the number of alcohol-related traffic fatalities based on a discriminant analysis of information from all cases for which driver or nonoccupant BAC data are available. There may be seasonal trends associated with these data.

Estimated number and percentage of total traffic fatalities* and drivers involved in fatal crashes, by age and blood alcohol concentration (BAC) level — United States, July–September 1991

		Fatalities by BAC†					
		BAC = 0.00		0.01% ≤ BAC ≤ 0.09%		BAC ≥ 0.10%	
Age (yrs)	No. fatalities§	No.	(%)	No.	(%)	No.	(%)
0–14	848	650	(76.6)	67	(7.9)	132	(15.5)
15–20	1,948	1,047	(53.8)	252	(12.9)	648	(33.3)
21–24	1,432	479	(33.4)	192	(13.4)	761	(53.1)
25–34	2,560	879	(34.3)	262	(10.2)	1,419	(55.4)
35–64	3,371	1,675	(49.7)	266	(7.9)	1,430	(42.4)
≥65	1,622	1,309	(80.7)	112	(6.9)	200	(12.4)
Total	**11,781**	**6,039**	**(51.3)**	**1151**	**(9.8)**	**4,590**	**(39.0)**

		Drivers¶ by BAC**					
		BAC = 0.00		0.01% ≤ BAC ≤ 0.09%		BAC ≥ 0.10%	
Age (yrs)	No. drivers§	No.	(%)	No.	(%)	No.	(%)
0–14††	55	49	(89.4)	5	(9.2)	1	(1.4)
15–20	2,383	1,679	(70.5)	226	(9.5)	478	(20.0)
21–24	1,954	1,026	(52.2)	225	(11.5)	704	(36.0)
25–34	4,035	2,390	(59.2)	336	(8.3)	1,309	(32.5)
35–64	5,080	3,710	(73.0)	263	(5.2)	1,107	(21.8)
≥65	1,448	1,303	(90.0)	58	(4.0)	87	(6.0)
Total	**14,955**	**10,157**	**(67.9)**	**1,113**	**(7.4)**	**3,686**	**(24.6)**

* Fatalities include all occupants and nonoccupants who died within 30 days of a motor vehicle crash on a public roadway.

† BAC distributions are estimates for drivers and nonoccupants involved in fatal crashes. Numbers of fatalities are rounded to the nearest whole number.

§ Includes only those for whom age is known.

¶ Driver may or may not have been killed.

** BAC distributions are estimates for drivers involved in fatal crashes. Numbers of drivers are rounded to the nearest whole number.

†† Although usually too young to legally drive, persons in this age group are included for completeness of the data set.

Source: Fatal Accident Reporting System, National Highway Traffic Safety Administration.

Erratum: Vol. 41, No. 37

In the article "Rapid Health Needs Assessment Following Hurricane Andrew—Florida and Louisiana, 1992," on page 687 in Table 2 the first item under the column heading "Household characteristic" should read "Unable to access medical services."

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